YOUTH SERVICES
OFFICE OF JUVENILE JUSTICE
PRE-EMPLOYMENT HEALTH INFORMATION

The attached health questionnaire is intended to verify your physical capability to safely perform the job for which you are being considered. It is not intended to take the place of exams given by your personal physician.

Name:		Social Security #:	
Address:	City:	State:	Zip Code:
Work Location:	Job Title:		

I certify that the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record shall be deemed sufficient cause for rejection of my application or dismissal after employment. I understand that I will not be entitled to future workers' compensation benefits if I knowingly and willfully conceal or make false representation about the information requested. I understand that the ***Office of Juvenile Justice (OJJ)*** will rely on this medical and occupational history in making a decision about my ability to safely perform my job.

Pre-existing Condition: OJJ requires that you provide us with a medical release from your treating physician before you can be cleared for work if you have a pre-existing condition which may impact your ability to perform your duties.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS. ALL INFORMATION PROVIDED IN THIS RECORD IS COMPLETE AND IS ACCURATE.

Signature of Applicant: _____ Date: _____

Witness:_____ Date:_____

1. ____ YES ____ NO Are you currently under the care of a physician/ health care provider?

If YES, please answer the following:

Physician/HCP treating you: _____

Diagnosis: _____

2. Circle each item that you have had a problem with in the past (meaning since birth to present):

A. MUSCLES, BONES, AND JOINTS (Pain, sprain, fracture, dislocation, surgery):

Neck Upper back Mid back Lower back Hip Knee Ankle Foot

Shoulder Elbow Wrist Hand Fingers Arthritis Gout

Provider comments: _____

B. SKIN: Itching Rash Hives Eczema

Provider comments: _____

C. CHEST AND LUNGS: Asthma Shortness of Breath

Provider comments: _____

D. NEUROLOGICAL: Seizures/Epilepsy Fainting Blackouts Muscle weakness Paralysis Numbness Tingling in hands, feet or face

Provider comments: _____

E. HEART: Heart problems? High Blood Pressure

Provider comments: _____

F. ENDOCRINE: Diabetes Thyroid problems Any other endocrine problems?

Provider comments: _____

G. GASTROINTESINAL (GI): Any history of stomach/ other GI problems? Hepatitis Hernia

Provider comments: _____

H. MENTAL HEALTH: Any uncontrolled anxiety/depression/other problems?

Provider comments: _____

I. INFECTIONS: Herpes infection of the finger? Cold sores Tuberculosis Hepatitis A B C (circle all)

Provider comments: _____

3. ____ YES ____ NO Do you have problems with latex gloves/other rubber products?

If YES, please identify the product: _____

4. ____ YES ____ NO Are there any other health conditions that you would like us to know about?

If YES, please explain: _____

5. ____ YES ____ NO Have you had the Chicken Pox/ Varicella?

6. ____ YES ____ NO Have you had the Measles?

7. ____ YES ____ NO Have you had the Mumps?

8. ____ YES ____ NO Have you had Rubella (3-day Measles)?

9. List Prescription Medications, Herbal Drugs and Over the Counter Medications that you are currently taking?

_____

_____

_____

10. List Allergies you have to food, drugs, pollens, chemicals, latex, etc:

_____

_____

11. ____ YES ____ NO A. Have you ever been hospitalized?

Explain: _____

_____

____ YES ____ NO B. Have you ever had surgery?

_____

YES NO C. Do you have persistent (**circle**) upper back pain, mid-back pain, low back pain, neck pain, or arm pain?

If yes:

Do you now have pain: **Rarely** **Occasionally** **Frequently**

- What is the longest period of time this bothered you?
- When was the last time you sought medical evaluation?
- ___Yes ___ No Do you have any numbness/tingling/weakness in your arms or legs? If yes, Where: _____
- ___Yes ___ No Have you had surgery or seen a surgeon for this problem?

IMMUNIZATIONS:

Please respond Yes, No, or NS (Not Sure)

1. ____ YES ____ NO ____ NS Tetanus Year: _____
2. ____ YES ____ NO ____ NS Hepatitis B Year: _____ If yes, titer; Year: _____ Results: _____
3. ____ YES ____ NO ____ NS Hepatitis A Year: _____
4. ____ YES ____ NO ____ NS MMR Year: _____ If yes, Rubella titer; Results: _____
5. ____ YES ____ NO ____ NS Varicella (Chicken Pox) Year: _____

PERSONAL HEALTH HABITS HISTORY:

1. ____ YES ____ NO Have you ever smoked?
   ____ YES ____ NO Are you a current smoker? If No, when did you quit? _____
2. ____ YES ____ NO Do you drink alcohol? How much do you drink each week?
3. ____ YES ____ NO Have you ever been treated for chemical (illegal or legal drugs or alcohol) dependency?
   Explain: _____

PAST WORK HISTORY:

1. Give your immediate past job title (Custodian, Administrative Assistant, Physician, etc)
   Length of time in this position: _____ Years _____ Months
2. ____ YES ____ NO Have you ever been injured on the job in any way? If yes, explain: _____
3. ____ YES ____ NO Have you ever received Workers Compensation benefits?
   If yes, please answer the following:
   - Name of employer at the time of injury? _____
   - Type of injury: _____
   - Date of injury: _____
   - Job title at time of injury: _____
   - How long were you off work: _____
4. ____ YES ____ NO Have you ever had to transfer from one job to another, or changed work duties because of health problems?
   Explain: _____
5. ____ YES ____ NO Have you ever been refused any job for health problems?
   Explain: _____
6. ____ YES ____ NO Has a doctor ever placed restrictions on the kind of work or activities you should do?
   Explain: _____
7. ____ YES ____ NO Have you ever received an impairment rating or a disability rating?
   Explain: _____

Applicant's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____